Washington State Department of Social & Health Services

SPOKEN LANGUAGE BROKERED INTERPRETER SERVICE APPOINTMENT RECORD

BROKER	CONTROL NUMBER
INTERPRETER AGENCY/INDEPENDENT	

DETERMINED BY BROKER AND REQUESTER

1. DSHS ADMINISTRATION/DIVISION REQUESTING INTERPRETER

Aging and Disability Services Administration (ADSA)
- ☐ Home and Community Services Division (HCSD)
- ☐ Division of Developmental Disabilities (DDD) *
- ☐ Residential Care Services (RCS)

Children's Administration (CA)
- ☐ Division of Children and Family Services (DCFS)
- ☐ Division of Licensed Resources (DLR)

Economic Services Administration (ESA)
- ☐ Community Services Division (CSD)
- ☐ Division of Child Support (DCS)
- ☐ Division of Employment and Assistance Programs (DEAP)
- ☐ Division of Child Care and Early Learning (DCCEL)

Health and Rehabilitation Services Administration (HRSA)
- ☐ Division of Alcohol and Substance Abuse (DASA)
- ☐ Division of Vocational Rehabilitation (DVR) *
- ☐ Mental Health Division (MHD)

☐ Juvenile Rehabilitation Administration (JRA)

Medical Assistance Administration (MAA)
- ☐ Division of Disability Determination Services (DDDS) *
- ☐ Division of Client Support/Interpreter Services Section

* Program Index | Allocation Code

2. PERSON REQUESTING APPOINTMENT (FIRST NAME, MIDDLE INITIAL, LAST NAME)	TITLE	ORGANIZATIONAL INDEX CODE

REQUESTER'S TELEPHONE NUMBER (INCLUDE AREA CODE)	DATE REQUEST MADE (MONTH, DAY, YEAR)

3. APPOINTMENT ADDRESS (NUMBER, STREET, CITY, AND ZIP CODE)

4. CLIENT'S FULL NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME) OR DASA APPROVAL NUMBER	5. GENDER ☐ Male ☐ Female	6. COMPLETE ONE OF THE FOLLOWING: **DO NOT INCLUDE BOTH NUMBERS** CLIENT ID NUMBER	PIC CODE (MEDICAL PROVIDERS ONLY)

7. CLIENT'S TELEPHONE NUMBER (INCLUDE AREA CODE)	8. LANGUAGE REQUESTED

COMPLETE EITHER LINE 9 OR LINE 10 BELOW. **DO NOT COMPLETE BOTH.**

9. INDIVIDUAL APPOINTMENT: APPOINTMENT DATE	SERVICE TYPE REQUESTED	SCHEDULED START TIME	ANTICIPATED END TIME
	☐ Social Service ☐ Medical		

10. BLOCK OF TIME APPOINTMENT: APPOINTMENT DATE	(NOT MAA) SERVICE TYPE REQUESTED	SCHEDULED START TIME	ANTICIPATED END TIME
	☐ Social Service		

COMPLETED BY INTERPRETER

11. PRINT NAME OF INTERPRETER PROVIDING SERVICE (FIRST NAME, MIDDLE INITIAL, LAST NAME)

12. ADDRESS AND CITY	ORIGIN	13. MILEAGE: TO APPOINTMENT	14. REIMBURSABLE MILEAGE
	DESTINATION	FROM APPOINTMENT	
	FINAL DESTINATION, IF APPLICABLE		

15. INTERPRETER SERVICES VERIFICATION

DATE OF SERVICE	INTERPRETER ARRIVAL TIME	SERVICE START TIME	SERVICE COMPLETION TIME	TOTAL BILLING TIME

16. INTERPRETER'S SIGNATURE	DATE

COMPLETED BY REQUESTER

17. Was the interpreter service completed? ☐ Yes ☐ No

For medical appointments, was the medical service ☐ Inpatient or ☐ Outpatient?

DO NOT SIGN unless sections above are completed. Be sure to check Section 15 for accuracy; the **interpreter's** name in Sections 11 and 16; and the interpreter's picture identification. Use Section 19 as needed. Consider verifying the interpreter is a DSHS certified interpreter.

18. SIGNATURE OF DSHS STAFF/MEDICAL PROVIDER (REQUESTER) CONFIRMING SERVICE DELIVERY	DATE

PRINT NAME HERE	TITLE/POSITION

19. COMMENTS

DSHS 17-123 (REV. 01/2003)

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